STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA	1100 S CURRY PK BLOOMINGTON, IN47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Recertification and State Licensure Survey. Survey dates: February 7, 8, 9 and 10, 2011 Facility number-000007 Provider number-155019 AIM number-100275040 Survey team: Marla Potts, RN, TC Melinda Lewis, RN (February 7, 8 and 9, 2011) Sharon Whiteman, RN Amy Wininger, RN Census bed type: SNF: 13 SNF/NF: 189 Total: 202 Census payor type: Medicare: 26 Medicaid: 130 Other: 46 Total: 202 Sample: 30 Theses deficiencies also reflect state			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings in accordance with 410 IAC 16.2. Quality Review completed on February 14, 2011 by Bev Faulkner, RN			

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F0157 SS=D	Based on record review and interview, the facility failed to ensure the physician was notified promptly when a resident was found on the floor and complained of right shoulder pain for 1 of 30 residents reviewed for physician notification in the sample of 30. Resident #201. Findings include: The clinical record for Resident # 201 was reviewed on 2/7/11 at 2:30 P.M. The record indicated Resident # 201 had diagnoses that included but were not limited to cerebrovascular accident (CVA-stroke) and senile dementia. The MDS [Minimum Data Set] assessment, dated 12/16/10, indicated Resident # 201 had severely impaired cognition. Resident # 201 required supervision with bed mobility and toilet use. Resident # 201 required limited assistance of one with transfers. Resident # 201 had not fallen since the last assessment. The Nurses Notes, dated 1/12/11 at 4:00 A.M., indicated "Res[resident] roommate came et got writer and said Res fell. Res found sitting upright on floor in room. Res stated fell et landed on R [right] shoulder. Res refused to allow ROM, grips et strength strong and equal bilat [bilateral]. c/o [complains of] R shoulder	F0157	It is the policy of Garden Villa to immediately inform the resident; consult with the resident's physician; and if known, notify the residents legal representative or an interested family member when there is a need to alter treatment significantly such as a need to discontinue an existing form of treatment due to to adverse consequences, or to commence a new form of treatment.Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #201 was followed by an orthopedic physician and therapy was started when orthopedic physician cleared resident to begin and is still currently working with therapy at this time. Follow up appointment was completed by orthopedic physician. Resident #201 has resumed to previous functional level. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All Residents have the potential to be affected by this practice. In service training was completed with all licensed staff regarding immediate notification to physician of any suspected injuries/change in condition. III.	03/02/2011

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	pain et PRN [as needed] Tylenol given at 3:45 AM..." The Nurses Notes, dated 1/12/11 at 7:00 A.M., indicated "Res seen by CNA using both arms to push self in w/c down hallway. faxed Dr (name) about fall et to ask for x-ray of R shoulder." The Nurses Notes, dated 1/12/11 at 12:30 P.M., indicated "N.O. [new order] recd [received] 1. May xray R shoulder. (Name) to obtain xray today..." The Nurses Notes, dated 1/13/11 at 4:00 A.M., indicated "R shoulder xray results received: Acute impacted humeral neck fracture with no displacement. Results faxed to Dr (name)." The Nurses Notes, dated 1/13/11 at 7:30 A.M., indicated "...No c/o's of pain during the noc. Res checked on q [every] 2 hours. Fax sent to Dr (name) for stronger pain med [medication] secondary to fracture." The Nurses Notes, dated 1/13/11 at 9:30 A.M., indicated "Call placed to (physician name) here at this time and recd N.O. 1. May refer to ortho for R humeral fx [fracture]. Set up appt [appointment] at (clinic name)..."		What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?Any suspected injury/change in condition will be called to a physician, not faxed. The on duty nurse will notify the on call nurse of any falls/change in condition. Together they will determine that all needs have been met and all protocols have been followed.IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?The on duty nurse will notify the on call nurse of any falls/change in condition. Together they will determine that all needs have been met and all protocols have been followed.Monthly a report will be given to Quality Assurance regarding the physician notification compliance gathered by the ADON to be monitored by the DON. This will be a 3 month consecutive report then reviewed for a change to quarterly review. V. Systemic changes will be completed by: 3/2/11	

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	In an interview with the Director of Nursing, on 2/9/11 at 12:40 P.M., indicated the staff should have been more timely with contacting the physician. The Director of Nursing provided the facility policy and procedure for Change in a Resident's Condition or Status, dated 3/04 at that time. The policy indicated "...The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: An accident or incident involving the resident..." 3.1-5(a)(1) 3.1-5(a)(3)			

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F0282 SS=D	Based on observation, interview and record review, the facility failed to ensure Resident #38 and Resident #26 was transferred according to the plan of care, in that both residents experienced falls for 2 of 17 residents reviewed for following the plan of care for falls in a sample of 30. Findings include: 1. Resident # 38 was identified during initial tour on 02/07/11 at 9:30 A.M., by Unit Manager #1 as not interviewable and having a history of falls. The clinical record of Resident #38 was reviewed on 02/07/11 at 1:00 P.M. The residents' diagnoses included, but were not limited to, Alzheimer's dementia, History of compression fractures T11 & T12 [Thoracic vertebra 11 & Thoracic vertebra 12], and osteoporosis. The resident was observed on 02/07/11 at 12:20 P.M., to be sitting in a wheelchair. Nurses Notes, dated 05/07/10 at 11:10 A.M., indicated, "...Found res [resident] lying on left side with back to toilet. CNA [Certified Nursing Assistant] stated that res legs buckled during transfer to	F0282	It is the policy of Garden Villa to provide services by qualified persons in accordance with each resident's written plan of care. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #38, a long term resident since 2002, has not had any further incidents related to staff not following the plan of care appropriately since May 2010. Resident #38 remains injury free and is monitored by facility staff daily due to altered safety awareness. Resident #26 has not had any further incidents with injuries since 1/12/11. Resident #26 remains injury free and is monitored by facility staff daily due to altered safety awareness. In service training has been completed with all nursing staff regarding the identified residents. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All Residents have the potential to be affected by this practice. In service training has been completed with all nursing staff regarding following care plans as directed. III. What measures will be put into place or	03/02/2011

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	toilet et [and] CNA lowered res to the floor." The Nurses Notes, dated 05/24/10 at 7:10 P.M., indicated, "Resident sitting up against wall. CNA voiced 'She is not hurt, I lowered her to the floor. We both slipped. I was trying to help her'...Staff education done of her being a 2 person lift...Intervention decided upon between this writer and RN on call-educate Station 2 staff of resident being 2 person assist." A care plan, dated 10/25/06, for the problem of "Transfers with ext. [extensive] assist X2 due to arthritis" included, but was not limited to, interventions of "keep call light within reach and answer promptly" A care plan for potential for falls indicated the resident had been lowered to the floor by staff in the bathroom on 05/07/10 and 05/24/10. The interventions included, but were not limited to, "05/07/10 Verbal counseling to staff for following assignment sheets...05/20/10 Memo in care tracker for following assignment sheets." In an interview with Unit Manager #1 on 02/07/11 at 1:20 P.M., she indicated, "The 05/07/10 fall was because the resident was a two person assist and there was only one person in there and the 05/24/10		what systemic changes will be made to ensure the deficient practice does not recur?Currently during orientation all nursing staff are educated on the need to follow care plans as directed and education continues throughout the length of their employment. In service training has been completed with all nursing staff regarding following the care plan as directed.IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?Director of Nursing and ADON will ensure that during all nursing staff orientation, education is completed regarding the following of care plans as directed. Quality Assurance will be given a report monthly regarding education. This will be a 3 month consecutive report then reviewed for a change to quarterly review V. Systemic changes will be completed by: 3/2/11	

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was the same thing, only one person in there. I put it on the care tracker on 05/20/10 so everyone would see it. It was different CNA's who got pulled to my unit."

2. Resident # 26 was identified during initial tour on 02/07/11 at 9:15 A.M. by Unit Manager #1 as not interviewable, and having a recent fall.

The clinical record of Resident #26 was reviewed on 02/08/11 at 3:00 P.M.

The residents' diagnoses included, but were not limited to, "left shoulder arthroplasty, osteoporotic compression L2 & L3 [Lumbar vertebrae 2 & 3], and osteoarthritis."

The resident was observed on 02/08/11 at 3:00 P.M., to be lying in a low bed with a scoop mattress.

The physician admission orders, dated 01/07/11, included, but were not limited to, "Up ad lib...up with assistance."

The CNA [Certified Nursing Assistant] Assignment Sheet provided by Unit Manager #1 on 02/07/11 at 9:00 A.M., indicated the resident required extensive

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	assist of one for transfers, low bed with scoop mattress and non-skid socks. Nurses Notes, dated 01/12/11 at 07:35 A.M., indicated, "This writer saw CNA at doorway of res [resident] room waving for me to come in room. I observed res sitting on the floor with her left leg straight out in front of her and her right leg and knee bent backwards towards her bottom...Her walker was at the side of the bed. She stated 'I hit the back of my head.' Res has a large size goose egg swelling to the back middle area of her head...." A care plan, dated 01/07/11, indicated the resident had a potential for falls. The interventions included, but were not limited to, Extensive assist of 1 for transfers, low bed, and scoop mattress. A care plan, updated 01/12/11, included , but was not limited to, an intervention "staff education on low bed and assignment sheet." In an interview with Unit Manager #1, on 02/08/11 at 3:30 P.M.,,. she indicated, the resident "was not in a low bed, she was in a scoop mattress. Staff forgot to lower bed, the intervention was staff education to lower the bed because they didn't do that...."			

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	Nurses Notes dated, 02/01/11 at 7:00 P.M., indicated, "Called to Station 2. Saw res. sitting in a hallway chair with Station 2 nurse. Nurse stated that res had fallen to her knees while ambulating independently with walker." A care plan for falls updated 02/01/11 indicated the resident had fallen and hit her head. The interventions, dated 02/01/11, included, but were not limited to, "staff education in caretracker...written warning to staff assisting resident." In an interview with Unit Manager #1, on 02/08/11 at 3:30 P.M., she indicated, "She was able to get up by herself because the walker was in reach and the bed was not in low position, I gave the CNA's a verbal warning for not following the assignment sheet." 3.1-35(g)(2)			

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F0315 SS=D	Based on observation, interview, and record review, the facility failed to ensure proper urinary catheter handling while providing care for 1 of 3 residents reviewed for urinary catheters in a sample of 30. (Resident #66) Findings Include: On 02/07/11 at 12:30 p.m., Resident #66 was observed seated in the dining room eating lunch. Resident #66 was observed to have a Foley (urinary) catheter with the catheter tubing dragging on the floor. On 02/07/11 at 12:33 p.m., CNA #3 was observed to propel Resident #66's wheelchair back to the resident's room. The resident's urinary catheter tubing was observed to drag the floor. On 02/07/11 at 12:35 p.m., CNA #3 and LPN #2 were observed to transfer Resident #66 from the resident's wheelchair to the resident's bed. CNA #3 was observed to remove the wheelchair footrests while ignoring the urinary catheter tubing on the floor. During the transfer, CNA #3 was observed to hand the urinary drainage bag to LPN #2. LPN #2 was observed to hold the drainage bag up above the resident's lap. Amber colored urine was observed to back flow	F0315	It is the policy of Garden Villa to provide a resident with urinary incontinence appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #66 had foley catheter for an extended period of time at home due to a diagnosis of urinary retention before admitting to the hospital. Resident #66 was admitted to this facility on 1/25/11 from the hospital with a foley catheter and a diagnosis of UTI. Resident #66 continues antibiotic therapy for UTI. In order to ensure proper catheter handling a velcro strap was used to form a loop in the catheter tubing thus keeping it from reaching the floor. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this practice. For all residents that have a foley catheter, to ensure proper catheter handling, a velcro strap was used to form a loop in the catheter tubing thus keeping it from reaching the floor. In service	03/02/2011

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	in the tubing. LPN #2 was observed to place the urinary drainage bag and tubing onto the floor. On 02/07/11 at 1:05 p.m., Physical Therapist #1 was observed to transfer Resident #66 from the resident's wheelchair to a therapy table. Physical Therapist #1 was observed to hang the resident's urinary drainage bag onto his trouser pocket during the transfer. On 02/08/11 at 9:10 a.m., Resident #66 was observed asleep in bed. The resident's urinary drainage bag and tubing were observed to be dragging on the floor. On 02/08/11 at 10:40 a.m., LPN #1 and CNA #2 were observed to give Resident #66 a bed bath. During the bed bath, CNA #2 was observed to place the resident's urinary drainage bag between (CNA #2's) legs to hold the drainage bag for assisting with transfer. On 02/08/11 at 11:10 a.m., Resident #66 was observed seated at the dining room table. The resident's urinary drainage tubing was observed to be dragging on the floor. Interview of Unit Manager #2 on 02/08/11 at 2:20 p.m., indicated facility policy was		training was completed with all nursing staff regarding the proper catheter handling.III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?In service training was completed with all nursing staff regarding the proper handling of foley catheters. The velcro strap was added as an additional intervention for proper catheter handling for all present and future foley catheter residents.IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?Direct observation will be utilized to ensure proper catheter handling by all staff. Monthly 100% of the residents with foley catheters will be observed for proper handling by the DON or designee. These observations will be presented to Quality Assurance monthly for review.V. Systemic changes will be completed by: 3/2/11	

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	to keep urinary drainage bags and tubing below residents' bladder and off the floor. Review of Resident #66's clinical record on 02/08/11 at 10:17 a.m., indicated the following: Resident #66 had diagnoses which included, but were not limited to, right hip fracture, possible movement disorder, and urinary retention. A care plan, dated 01/25/11, indicated, "...Risk for UTI (urinary tract infection) due to Foley catheter currently for UTI...Cipro 500 mg (milligrams) (antibiotic medication)...." A care plan, dated 01/25/11, indicated, "Risk for UTI due to (Foley catheter)...Current for UTI...Cipro 500 mg (by mouth twice daily)...Maintain catheter per protocol." A policy titled "Catheter Care" was provided by Unit Manager #2 on 02/08/11 at 2:20 p.m. The policy indicated, "The purpose of this procedure is to prevent infection of the resident's urinary tract...The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing			

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	back into the urinary bladder...Be sure the catheter tubing and drainage bag are kept off the floor. 3.1-41(a)(2)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=D	Based on observation, interview, and record review, the facility failed to ensure interventions to prevent falls were consistently implemented, in that staff failed to follow the care plan resulting in falls, for 3 of 17 residents reviewed for falls in the sample of 30. Resident #215, #38 and 26. Findings include: 1. The clinical record for Resident # 215 was reviewed on 2/7/11 at 3:00 P.M. The record indicated Resident # 215 had diagnoses that included but were not limited to Alzheimer's disease with senile dementia. The MDS [Minimum Data Set] assessment, dated 10/29/10, indicated Resident # 215 had severely impaired cognition. Resident # 215 required extensive assistance of two with bed mobility, transfers and toilet use. Resident # 215 required limited assistance of two with ambulation, and had a fall with major injury since the last assessment. A care plan, dated 2/5/09 and updated on 1/17/11, indicated a problem of "Risk for falls characterized by history of falls, multiple risk factors related to:	F0323	It is the policy of Garden Villa to ensure that the resident environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Residents #215, 26, and 38 have all had their care plans reviewed and updated so all fall interventions are resident specific and appropriate. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this practice. All resident care plans with new fall interventions since 2/1/11 have been reviewed and updated to be resident specific and appropriate. In service training was completed with all nursing staff regarding the need to follow care planned interventions as directed for all residents. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?In service training was completed with all nursing staff	03/02/2011

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	155019	A. BUILDING _____ B. WING _____	02/10/2011

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	independent with ambulation and transfers and locomotion on and off unit, antidepressant and antipsychotic therapy. Fall 1-14-11- fall out of rocking chair in room." The interventions included "Have commonly used articles within easy reach. Resident to wear proper and non slip footwear. Encourage resident to use handrails or assistive devices properly. Keep walkways free of clutter including keppin(sic) DR enterance (sic) open. Complete and review fall risk assessment quarterly and after each fall. May have high/low bed with scoop mattress. Administer Zoloft (antidepressant) 150 mg po [by mouth] QD [everyday]. Ensure adequate lighting. Call light in reach and answer promptly. Monitor for incontinence at least every 2 hours. Non skid socks at noc [night] night light in bathroom. Reeducated staff on picking up beads up for res or redirecting. To utilize gait belt when walking outside with staff. Remove loose beads from dresser in lounge. UA+ [urinalysis], B/P q [every] shift x [times] 3 days." The Fall Risk Assessment, dated 7/16/10, indicated a score of 14. The form indicated "Total score above 10 represents HIGH RISK." The Fall Risk Assessment, dated 9/3/10,		regarding the need for resident specific fall interventions. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?Every fall will be reviewed by the on duty nurse and the on call nurse. The ADON will then review all applicable paper work regarding the fall and interventions. A monthly report will be given to Quality Assurance regarding accidents/incidents by the ADON to be monitored by the DON. V. Systemic changes will be completed by: 3/2/11	

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indicated a score of 13. The form indicated "Total score above 10 represents HIGH RISK." The Ongoing/ periodic evaluation for 9/3/10 indicated "Res tripped over another res's foot at entrance to DR [dining room] et fell on R side. Staff moved chairs away from entrance to hall/DR to make area more open."

The Nurses Notes, dated 10/18/10 at 6:30 P.M., indicated "Staff heard chairs moving across the floor et [and] noted res lying on L [left] side holding head. Res had just gotten up from table at dinner. Staff assessed res et noted bump to back of res's head. Res c/o [complaints of] pain to L side/hip as staff was checking ROM [range of motion]. MD et POA [power of attorney] notified. N.O. [new order] rec'd [received] Send to ER [emergency room] for evaluation et tx [treatment]."

The Nurses Notes, dated 10/18/10 at 8:30 P.M., indicated "Res ret [returned] to facility at this time with dx [diagnosis of] simple L [left] pelvis fx [fracture]..."

The Fall Risk Assessment, dated 10/18/10, indicated a score of 15. The form indicated "Total score above 10 represents HIGH RISK." The Ongoing/periodic evaluation for 10/18/10 indicated "Res fell onto L side in DR. Res

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	had just finished supper and had got up. Res c/o L leg pain. Sent to ER [emergency room]. Initiated neuro checks. 1:1 [one to one] supervision as nursing measure on return from ER." The Fall Risk Assessment, dated 10/29/10, indicated a score of 16. The form indicated "Total score above 10 represents HIGH RISK." The Nurses Notes, dated 11/25/10 at 4:30 A.M., indicated "Res found sitting up on floor in BR between door et w/c at 152 AM [sic]. Res was in bed at 140 AM [sic] when CNA checked on her. At 150 AM [sic] another CNA walked down hallway et noticed the door to her room closed when it was open earlier and went in and found her. Res moved all extremities and denied pain at time of fall. Noted 0.6 cm x 0.8 cm skin tear with L [left] elbow (sic). Unsure if happened with this fall or earlier combative behavior on earlier shift...Res toileted et brought to lounge in recliner facing nurses desk for closer supervision..." The Fall Risk Assessment, dated 11/25/10, indicated a score of 21. The form indicated "Total score above 10 represents HIGH RISK." The Ongoing/periodic evaluation for 11/25/10			

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indicated "Res got up unassisted and took w/c into BR, found sitting on floor in BR. Res brought to lounge in recliner resting for closer supervision. Hip savers at all times."

The fall care plan, dated 2/5/09 and updated on 1/17/11, had the intervention of hip savers on at all times initiated on 11/25/10.

The Nurses Notes, dated 11/28/10, no time, indicated "Res found by CNA sitting on the floor on her buttocks. Res had apparently got OOB [out of bed] crawled over the mattress extensions then attempted to stand up then sat on her bottom. Res had an skin tear to the R [right] elbow area approx [approximately] 0.25 x [by] 0.25 very minimal bleeding noted..."

The Nurses Notes, dated 12/12/10 at 9:15 P.M., indicated "Res found lying on L side in bathroom. Res had previously gone to bed with 1:1 [one to one] staff in room until res had fallen asleep. Res states was going to bathroom...Noted skin tears to L elbow meas [measures] 1 x 1 cm prox [proximal] et .5 x 2 cm (distal)...Noted res had removed nonskid socks. Res was assisted back into w/c with assist of 2 and brought to lounge to

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	monitor..." The Fall Risk Assessment, dated 12/12/10, indicated a score of 21. The form indicated "Total score above 10 represents HIGH RISK." The Ongoing/periodic evaluation for 12/12/10 indicated "Res got up unassisted et went in to BR. Found lying L side. Res assessed had removed nonskid socks. Res brought to lounge for closer supervision. Constant supervision while up." The fall care plan, dated 2/5/09 and updated on 1/17/11, had the intervention of constant supervision while up, toileting plan initiated on 12/13/10. The Nurses Notes, dated 12/19/10 at 8:30 P.M., indicated "Writer found res sitting up in front of w/c on st (number) lounge area at the supper table. Activity Assistant witnessed res rise up from her w/c. She put her one hand on her own w/c et attempted to place her other hand on another res. w/c but missed. Visitor caught res before her head could hit the floor. Res has small abrasion/more of a sm [small] reddened area on her R [right] middle of back. No other injuries noted...Incident happened at 5:25 pm. Immediate intervention is 1 on 1 at this x [time]..."			

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The Fall Risk Assessment, dated 12/19/10, indicated a score of 15. The form indicated "Total score above 10 represents HIGH RISK." The Ongoing/periodic evaluation for 12/19/10 indicated "Res got up out of w/c. Placed her hand on her w/c et her other hand on another res w/c but missed et slid to the floor. Visitor kept res from hitting her head on the floor. AA [activity assistant] unable to get to res in time. Res has constant supervision while up. Walk to dine."

The fall care plan, dated 2/5/09 and updated on 1/17/11, had the intervention of Walk to dine program- to walk res to DR and sit in reg [regular] chair initiated on 12/20/10.

The Nurses Notes, dated 1/14/11 at 11:45 P.M., indicated "Res found in floor in her room sitting on buttocks by rocking chair. Res had been in w/c and went in room and was sitting in rocking chair and pad came out of rocking chair onto floor. No injuries..."

The Fall Risk Assessment, dated 1/14/11, indicated a score of 21. The form indicated "Total score above 10 represents HIGH RISK." The Ongoing/periodic

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	evaluation for 1/14/11 indicated "Res fell out of rocking chair in room no injury Dycem to rocking chair staff education." The fall care plan, dated 2/5/09 and updated on 1/17/11, had the intervention of Dycem to rocking chair under pad, staff education initiated on 1/17/11. In an interview with the Alzheimer's Unit Manager, on 2/9/11 at 12:10 P.M., she indicated the staff education provided on 1/17/11 was because one of the aides had left the resident in her room unattended and they should have known she was on constant supervision and the staff should have known better.			

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F0323 SS=D	2. Resident # 38 was identified during initial tour on 02/07/11 at 9:30 A.M. by Unit Manager #1 as not interviewable and having a history of falls. The clinical record of Resident #38 was reviewed on 02/07/11 at 1:00 P.M. The residents' diagnoses included, but were not limited to, Alzheimer's dementia, History of compression fractures T11 & T12 [Thoracic vertebrae 11 & Thoracic vertebrae 12], and osteoporosis. The resident was observed on 02/07/11 at 12:20 P.M. to be sitting in a wheelchair. The most recent MDS [Minimum Data Set Assessment], dated 11/09/10, indicated the resident was unable to stand without physical help. The MDS further indicated the resident was severely cognitively impaired and required extensive assist of two persons for transfers. A care plan, dated 10/25/06, for the problem of "Transfers with ext. [extensive] assist X2 due to arthritis" included, but was not limited to, interventions of "keep call light within reach and answer promptly"	F0323	It is the policy of Garden Villa to ensure that the resident environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Residents #215, 26, and 38 have all had their care plans reviewed and updated so all fall interventions are resident specific and appropriate. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this practice. All resident care plans with new fall interventions since 2/1/11 have been reviewed and updated to be resident specific and appropriate. In service training was completed with all nursing staff regarding the need to follow care planned interventions as directed for all residents. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?In service training was completed with all nursing staff	03/02/2011

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	Nurses Notes dated 05/07/10 at 11:10 A.M., indicated, "...Found res [resident] lying on left side with back to toilet. CNA [Certified Nursing Assistant] stated that res legs buckled during transfer to toilet et [and] CNA lowered res to the floor." The Nurses Notes, dated 05/24/10 at 7:10 P.M., indicated, "Resident sitting up against wall. CNA voiced 'She is not hurt, I lowered her to the floor. We both slipped. I was trying to help her'...Staff education done of her being a 2 person lift...Intervention decided upon between this writer and RN on call-educate Station 2 staff of resident being 2 person assist." A care plan for potential for falls indicated the resident had been lowered to the floor by staff in the bathroom on 05/07/10 and 05/24/10. The interventions included, but were not limited to, "05/07/10 Verbal counseling to staff for following assignment sheets...05/20/10 Memo in care tracker for following assignment sheets." The Fall Risk Assessment completed on 05/06/10 indicated the resident scored a "22". The Assessment indicated a score of above 10 represented a "HIGH RISK". In an interview with Unit Manager #1 on		regarding the need for resident specific fall interventions. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?Every fall will be reviewed by the on duty nurse and the on call nurse. The ADON will then review all applicable paper work regarding the fall and interventions. A monthly report will be given to Quality Assurance regarding accidents/incidents by the ADON to be monitored by the DON. V. Systemic changes will be completed by: 3/2/11	

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	02/07/11 at 1:20 P.M. she indicated, "The 05/07/10 fall was because the resident was a two person assist and there was only one person in there and the 05/24/10 was the same thing, only one person in there. I put it on the care tracker on 05/20/10 so everyone would see it. It was different CNA's who got pulled to my unit." 3. Resident # 26 was identified during initial tour on 02/07/11 at 9:15 A.M. by Unit Manager #1 as not interviewable, and having a recent fall. The clinical record of Resident #26 was reviewed on 02/08/11 at 3:00 P.M. The residents' diagnoses included, but were not limited to, "left shoulder arthroplasty, osteoporotic compression L2 & L3 [Lumbar vertebrae 2 & 3], and osteoarthritis." The resident was observed on 02/08/11 at 3:00 P.M. to be lying in a low bed with a scoop mattress. Nurses Notes, dated 01/12/11 at 07:35 A.M., indicated, "This writer saw CNA at doorway of res [resident] room waving for			

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	me to come in room. I observed res sitting on the floor with her left leg straight out in front of her and her right leg and knee bent backwards towards her bottom...Her walker was at the side of the bed. She stated 'I hit the back of my head.' Res has a large size goose egg swelling to the back middle area of her head..." A care plan, dated 01/07/11, indicated the resident had a potential for falls. The interventions included, but were not limited to, Extensive assist of 1 for transfers, low bed, and scoop mattress. A care plan updated 01/12/11 included , but was not limited to, an intervention "staff education on low bed and assignment sheet." In an interview with Unit Manager #1 on 02/08/11 at 3:30 P.M., she indicated, the resident "was not in a low bed, she was in a scoop mattress. Staff forgot to lower bed, the intervention was staff education to lower the bed because they didn't do that ..." Nurses Notes, dated 02/01/11 at 7:00 P.M., indicated, "Called to Station 2. Saw res. sitting in a hallway chair with Station 2 nurse. Nurse stated that res had fallen to her knees while ambulating independently with walker."			

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A care plan for falls updated 02/01/11 indicated the resident had fallen and hit her head. The interventions, dated 02/01/11, included, but were not limited to, "staff education in caretracker...written warning to staff assisting resident."

In an interview with Unit Manager #1, on 02/08/11 at 3:30 P.M., she indicated, "She was able to get up by herself because the walker was in reach and the bed was not in low position, I gave the CNA's a verbal warning for not following the assignment sheet."

The Fall Risk Assessment completed on 01/07/11 indicated the resident scored a "18". The Assessment indicated a score of above 10 represented a "HIGH RISK".

The CNA Core Curriculum for the Nurse Aide Training Program of July 1998 indicated, "Topic 22: Transferring 1. Moving or transferring a resident...requires... with emphasis on planning and safety...To prepare for a move:...determine if you need help to move the resident safely.

3.1-45(a)(2)

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F0333 SS=D	Based on interview and record review, the facility failed to ensure residents were free of significant medication errors in that a resident's medication to control her blood pressure was not given as ordered by the attending physician, resulting in the medication being held when it should have been given, for 1 of 30 residents reviewed for medication administration, in the sample of 30. Resident #202 Findings include: The clinical record for Resident # 202 was reviewed on 2/7/11 at 1:00 P.M. The record indicated Resident # 202 had diagnoses that included but were not limited to dementia and hypertension. The MDS [Minimum Data Set] assessment, dated 10/20/10, indicated Resident # 202 had severely impaired cognition. Resident # 202 was independent with bed mobility and required supervision with transfers, ambulation, and toilet use. Resident # 202 had no falls. A Physician order, dated 11/1/10, included but were not limited to the following orders: "Norvasc 10 mg take 1 tablet by mouth daily *Hold if SBP [systolic blood pressure (the upper number of the blood	F0333	It is the policy of Garden Villa to ensure that residents are free from any significant medication errors. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #202's medication administration record has been revised to clearly indicate when to administer or hold a medication. Resident 202's physician has been notified of all medication errors that resulted in November 2010. After review of Resident 202's record no further medication errors have occurred since November 2010. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this practice. Any medications in question of being held must be reported to the RN on call for approval. In service training was completed with all medication administration staff regarding proper parameters for holding medications. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?Weekly all medication administration records, for residents that have	03/02/2011

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	pressure)] < [less than] 100* and Atenolol 50 mg take 1 tablet by mouth daily *Hold if P [pulse] < 60 or SBP <100 check blood pressure daily. Lisinopril 20 mg take 1 tablet by mouth two times a day *Hold if SBP < 100." The Nurses Notes, dated 11/11/10 at 9:00 A.M., indicated "Called by staff noted res [resident] sitting on floor on buttocks noted hematoma on back of head res stated "I got dizzy and fell I hit my head"...c/o [complains of] headache...B/P 178/74..." The Nurses Notes, dated 11/11/10 at 1:30 P.M., indicated "Medication error noted in that Norvasc (blood pressure medication) and Atenolol (blood pressure medication) were held on the dated of 11/1, 11/5, 11/6, 11/7, 11/9, 11/10, 11/11 when meds were not needed to be held and pulse and/or B/P were WNL [within normal limits]. MD notified..." The November 2010 Medication Administration Record (MAR) indicated on 11/1/10 at 8:00 A.M. the blood pressure was 119/51 with the Norvasc held. On 11/5/10 at 8:00 A.M. the blood pressure was 116/56 with the Norvasc held.		parameters associated with a medication, will be reviewed by nursing administration. Any medications in question of being held must be reported to the RN on call for approval. The RN on call will keep a log of calls received and approvals given. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?Monthly a report will be given to Quality Assurance regarding the held medications and RN notification. This information will be reported for 3 consecutive months then will be up for quarterly review. V. Systemic changes will be completed by: 3/2/11	

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	On 11/6/10 at 8:00 A.M. the blood pressure was 117/76 with the Norvasc held. On 11/7/10 at 8:00 A.M. the blood pressure was 133/48 and the pulse was 73 with both the Norvasc and Atenolol held. On 11/9/10 at 8:00 A.M. the blood pressure was 132/68 and the pulse was 74 with both the Norvasc and Atenolol held. On 11/9/10 at 8:00 P.M. the blood pressure was 110/49 with the Lisinopril held. On 11/10/10 at 8:00 A.M. the blood pressure was 144/77 and pulse was 61 with both the Norvasc and Atenolol held. On 11/11/10 at 8:00 A.M. the blood pressure was 131/69 and pulse was 67 with both the Norvasc and Atenolol held. On 11/12/10 at 8:00 A.M. the pulse was 64 with the Atenolol held. On 11/12/10 at 8:00 P.M. the blood pressure was 127/58 with the Lisinopril held. On 11/20/10 at 8:00 P.M. the blood pressure was 112/48 with the Lisinopril held. On 11/21/10 at 8:00 P.M. the blood pressure was 120/58 with the Lisinopril held. On 11/23/10 at 8:00 A.M. the blood pressure was 120/50 with the Norvasc held. On 11/24/10 at 8:00 A.M. the pulse was			

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	60 with the Atenolol held. On 11/30/10 at 8:00 P.M. the blood pressure was 123/57 with the Lisinopril held. During interview on 2/10/11 at 10:00 A.M., the Director of Nursing,(DoN) indicated she was not aware of medication errors continuing after 11/11/10, when the facility had reported the errors to the physician. The DoN indicated as the facility was not aware of the errors they had not documented the errors nor reported it to the physician. The DoN further indicated that a facility wide inservice was held on correct medication administration the first of December 2010 on all units. 3.1-25(b)(9) 3.1-48(c)(2)			

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F0441	Based on interview, observation, and record review, the facility failed to ensure nursing staff washed their hands or changed gloves according to facility policy while providing resident care for 2 of 30 sampled residents and 1 random resident reviewed for infection control practices, and failed to ensure a shower chair was cleansed after use for 1 of 1 random showers observed on 1 of 7 units, in a sample of 30. (Resident #74, Resident #54, and Resident #27 and Random #32) Findings Include:	F0441	It is the policy of Garden Villa to establish and maintain an infection control program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements.I. What corrective action(s) will be accomplished for those residents found to have been affected by the defienct practice?All staff that cared for the identified residents were in serviced on proper infection control practices. Resident #54 remains free from facility aquired infections. Resident #54 has been transferred to a different room in the facility. Resident #74 has had bed linens and pillow changed and call light cleaned. Resident #27 remains free from facility aquired infection. Resident #27 has had all bed linens changed.Resident #32 remains free from facility aquired infections. The shower chair used by resident #32 was disinfected on 2/7/11. II. How other residents having the potential to be affected by the same defiecient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this practice. In service training was completed	03/02/2011

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	1. On 02/07/11 at 12:55 p.m., CNA #3 was observed to wear gloves during care of Resident #54. CNA #3 was observed to handle Resident #54's gastrostomy tubing and to dress Resident #54 and to handle a sheet which "has a little urine on it." CNA #3 was observed to not change gloves or wash her hands before using a gait belt (which had been around the CNA's waist) to transfer the resident and to hand the resident his cell phone and glasses. 2. On 02/07/11 at 2:20 p.m., CNA #4 was observed to wear gloves while		with all staff regarding infection control practices. Direct observation of nursing staff is being conducted randomly for proper infection control compliance. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?On going education and direct observation will continue to ensure proper infection control compliance. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?Monthly a report will be given to Quality Assurance regarding infection rates and results of direct observations. This will be an on going report. V. Systemic changes will be completed by: 3/2/11	

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	transferring Resident #74 from the resident's wheelchair to her bed. CNA #4 was observed to wear gloves while removing Resident #74's slacks and adult brief and handling a wound dressing which had fallen off the resident's buttocks area. CNA #4 was observed to not change gloves or wash her hands before placing a pillow under the resident's leg, straightening the resident's blankets over the resident, and handing the resident her call light. 3. On 02/09/11 at 9:30 a.m., CNA #1 was observed to wear gloves while			

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	providing care for Resident #74. CNA #1 was observed to wash the resident's face and hands and to remove a wet brief and wash the resident's bottom. CNA #1 was observed to not change gloves or wash her hands before straightening the resident's blankets over the resident, handing the resident her call light, and putting safety floor mats back in place. A policy titled "Handwashing/Hand Hygiene" was provided by the Director of Nursing (DON) on 02/10/11 at 10:40 a.m. The policy indicated, "...Purpose: The			

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	purpose of this procedure is to provide guidelines to employees for proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections....Objective: To prevent and to control the spread of infectious diseases...The use of gloves does not replace handwashing. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations...before direct contact with residents...Before moving from a contaminated body site of a clean body site during resident care...After			

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	contact with resident's intact skin...."			

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F0441	4. During observation of pericare for Resident #27, on 02/09/11 at 9:25 A.M., CNA [Certified Nursing Assistant] #5 was observed to don gloves and provide pericare with her right gloved hand. CNA #5 was observed to transfer Resident #27 to the bed, touching the resident's gown and bed linens with the gloved right hand. During an interview with CNA #5, on 02/09/11 at 9:30 A.M., she indicated, "We change gloves before and after care." 5. Following observation of a shower provided by CNA #6 to Random Resident # 32, on 02/07/11 at 2:15 P.M., CNA #6 failed to disinfect the shower room. The policy and Procedure for Shower/Tub Bath provided by the DoN [Director of Nursing], on 02/09/11 at 12:30 P.M., indicated, "Infection Control Protocol and Safety...5. After completion of the procedure, clean, ...equipment and supplies in the appropriate manner as identified per facility infection control policy." During an interview with CNA #6, on 02/07/11 at 2:35 P.M., she indicated, "I'm done with the shower."	F0441	It is the policy of Garden Villa to establish and maintain an infection control program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements.I. What corrective action(s) will be accomplished for those residents found to have been affected by the defienct practice?All staff that cared for the identified residents were in serviced on proper infection control practices. Resident #54 remains free from facility aquired infections. Resident #54 has been transferred to a different room in the facility. Resident #74 has had bed linens and pillow changed and call light cleaned. Resident #27 remains free from facility aquired infection. Resident #27 has had all bed linens changed.Resident #32 remains free from facility aquired infections. The shower chair used by resident #32 was disinfected on 2/7/11. II. How other residents having the potential to be affected by the same defiecient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this practice. In service training was completed	03/02/2011

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	During an interview with CNA #6, on 02/07/11 at 2:50 P.M., she indicated, "I didn't clean or spray off the chair. CNA's are supposed to clean it between residents. We spray disinfectant with the spray pump, wipe it off, then spray it off." 3.1-18(l)		with all staff regarding infection control practices. Direct observation of nursing staff is being conducted randomly for proper infection control compliance. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?On going education and direct observation will continue to ensure proper infection control compliance. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?Monthly a report will be given to Quality Assurance regarding infection rates and results of direct observations. This will be an on going report. V. Systemic changes will be completed by: 3/2/11	